Overview of Missouri State Medicaid Program and Medicaid Fraud Control Unit

The single state agency for Medicaid in Missouri is the Missouri Department of Social Services (DSS). Within Social Services, the MO HealthNet Division (MHD) is responsible for the administration of the health related services as detailed in Title XIX, Public Law 89-97, 1965 amendments to the federal Social Services Act, 42 U.S.C. Section 301. The Missouri Medicaid Fraud Control Unit (MFCU), operates a statewide program for the investigation and prosecution of health care providers who defraud the Medicaid program,[1] and is housed in the Missouri Attorney General's Office, Public Safety Division. The MFCU works closely with DSS and originally entered into a Memorandum of Understanding (MOU) with DSS when the Medicaid Fraud Control Unit was created in 1994. The most recent MOU between DSS and the MFCU was entered into on June 29, 2010. Staff of the MFCU attend regular meetings with DSS to discuss recent referrals, shared initiatives, ongoing investigations and other matters.

The MFCU receives fraud, abuse, and neglect referrals from various private and public sources including the Program Integrity Unit and Investigations Unit within DSS, other state and federal agencies, other states, private attorneys, and other private citizens. (*See* Section I – Referrals, below). All referrals are logged in and tracked on the MFCU database. If, after initial review, a referral is deemed to warrant additional investigation, a formal investigation is opened. If an investigation reveals actionable conduct by a Medicaid provider, MFCU staff can pursue either a civil or criminal case or both. MFCU staff also routinely participates in multistate fraud investigations.

Most referrals received are regarding Medicaid fraud, though complaints of abuse and neglect of residents in public facilities and complaints of misappropriation of patient private funds are also reviewed by MFCU. The Department of Health and Senior Services (DHSS) operates a 24-hour hotline for patient abuse and neglect complaints and conducts disqualification hearings for employees of health care facilities who are accused of abuse and neglect. A system has been

[1] *See* §191.900 – 191.914, RSMo.

established to insure that the MFCU receives field complaints of abuse and neglect simultaneously with DHSS.

In state cases, the MFCU participates in cooperative efforts with county prosecuting attorneys, as well as local law enforcement and administrative agencies. In joint state/federal cases, the MFCU works closely with the United States Attorney's Office, Department of Health and Human Services, Office of Inspector General (HHS-OIG), with the Federal Bureau of Investigation, Department of Defense Criminal Investigative Service, Internal Revenue Service, Social Security Administration, and U.S. Postal Inspectors. Federal authorities maintain the option to criminally charge conduct established during joint investigations. In addition, MFCU staff members routinely work with the state Managed Care Organizations (MCOs) and other private insurers and providers, including information sharing on potential areas of fraud as well as national trends.

Data herein reflects MFCU activity from January 1 through December 27th, 2010.

I. Referrals

The MFCU receives fraud and/or abuse referrals from a number of sources and in a number of ways. Fraud and abuse referrals may stem from various private and public sources including other state and federal agencies, other states, private attorneys, and other private citizens. The MFCU maintains both a phone "hotline" number[2] and an on-line complaint form as means for the public to report suspected fraud or abuse.[3]

During Calendar Year 2010, the MFCU received a total of 353[4] referrals from all sources. Each referral is preliminarily reviewed to determine if it is from a credible source, can be

[2] The MFCU hotline referral number is: (800) 286-3932
[3] Complaints can be submitted online at http://ago.mo.gov/divisions/medicaid-fraud-control-unit-faqs.htm.
[4] This number includes 9 complaints of resident abuse or "Violations of Resident's Rights" received. Pursuant to §198.093 RSMo, all of these complaints are opened into investigations.

substantiated and is serious in nature. During 2010, 123 referrals were opened into 'complaints' – active investigations.

II. Investigations

The MFCU conducts state investigations, joint state/federal investigations, and multi-state investigations throughout the year. MFCU began Calendar Year 2010 with 131 open investigations. After opening an additional 123 during 2010 and closing a total of 131, MFCU closed the year with 123 investigations pending.

Below is a summary of the 123 MFCU state and federal investigations opened during Calendar Year 2010 listed by provider type. This table shows the number of investigations initiated and the number closed during 2010. Because investigations can take more than 12 months to be resolved, the number of closed investigations includes investigations that may have been opened prior to January 1, 2010. In addition to the cases listed in the table below, the MFCU has participated in approximately 60 multi-state cases during Calendar Year 2010.

Provider Type		Initiated	Closed	Pending
CL	Clinic	4	5	5
DE	Dentist	7	8	12
DM	Durable Medical Equipment	3	2	2
DO	Osteopathic Physician	2	3	3
HH	Home Health	19	10	16
HO	Hospital	1	2	2
LA	Laboratory	1	1	1
MD	Physician	4	2	7

Provider Type		Initiated	Closed	Pending
NH	Nursing Home	4	4	1
OD	Optometrist/Optician	0	0	0
OF	Other Facility	2	5	9
OI	Other Institutions	0	0	0
OM	Other Medical Support	1	0	1
OP	Other Practitioner	1	1	2
OT	Other	12	8	11
PA	Patient Abuse	37	47	10
PD	Psychologist	1	8	7
PF	Patient Funds	1	10	3
PH	Pharmacy	3	8	8
PM	Psychiatrist	0	0	3
PO	Podiatrist	1	0	2
PP	Prepaid Health	0	0	0
PT	Pharmaceutical	19	6	18
SA	Substance Abuse	0	0	0
TR	Transportation	0	1	0
XI	X-Ray Imaging	0	0	0
	TOTAL	**123**	**131**	**123**

Below is a table summarizing the age of the investigations closed by the MFCU during Calendar Year 2010.

	0 - 6 Months	7- 12 Months	12 - 24 Months	25 - 36 Months	More than 36 Months	TOTAL
Fraud Investigations	35	28	19	10	18	**110**
Abuse Investigations	8	3	2	0	0	**13**
TOTAL	**43**	**31**	**21**	**10**	**18**	**123**

III. Total Overpayments Identified

Overpayments are the amounts paid to a provider in excess of the amount appropriately earned for the service rendered. In some scenarios, this number can be readily determined. For instance, a provider bills – and is paid – for a service not provided and the total amount billed is an 'overpayment'. In other matters, an actual overpayment amount cannot be determined. For example, a facility may bill for and be paid for caring for a recipient – but then delivers care that is marginally but not wholly substandard, or a drug company may use unlawful marketing schemes to create greater demand for its products, but measuring that illicit demand growth and placing a monetary value on the Medicaid "loss" in any specific drug sale, is problematic. This is particularly true when the parties agree to a settlement without coming to an agreement on each specific financial component. In such instances, the MFCU records the total amount of the settlement as damage to the Medicaid Program.

In the event a MFCU investigation reveals that a provider incorrectly – but not fraudulently – obtained reimbursement from the Medicaid program, the MFCU can refer the matter back to DSS's Program Integrity to potentially pursue an overpayment. There are such occasions where an exact overpayment figure cannot be identified by the MFCU because the MFCU does not evaluate program rules violations. While the rule violations may merit administrative recovery of an overpayment to a provider, that conduct may not be actionable under Chapter 191. In these instances, referrals can be made to PI describing the provider's conduct,

thus enabling PI to identify the amount overpaid, if indicated. In other matters, the conduct investigated and charged does not include all of what a provider may have been overpaid.

In matters that MFCU completed investigations and derived an overpayment amount, the 2010 total was $7,420,946.06.

IV. Total Fines and Restitution Ordered

In Calendar Year 2010, the MFCU obtained total recoveries – the sum of all restitution and fines ordered – in the amount of $19,831,805.07. Of this amount, $7,420,946.06 was for overpayments or restitution (see above) and $12,395,859.01 was for fines and penalties, and another $15,000.00 was for investigative costs, etc.

In general, when the MFCU obtains a recovery for the Medicaid program, payment is made in a lump sum at or near the time of the judgment or settlement. In larger cases where some delay in payment is expected, interest is charged for the period between settlement date and pay out date.[5] The rate has fluctuated monthly between 2.8% and 3.4% since 2008.

There are rare resolutions in which the amounts are paid to other entities. For example, in one instance a nursing home bookkeeper stole nursing home residents' personal funds out of a "resident trust fund." The nursing home's management company paid the residents back for the amount of the theft, and at sentencing, restitution was ordered to be paid to the nursing home management company. In 2010, the total amount of restitution recovered for other entities was $14,612.21.

There were four cases resolved in Calendar Year 2010 which provided for installment payments; all but one has been paid in full. The remaining installment payment represents the restitution mentioned above and is being handled by the Perry County Prosecutor's Office.

[5] Interest rate is based on Medicare Trust Fund rate as published monthly by the HHS's Centers for Medicare and Medicaid Services.

MFCU does not allow providers to pay amounts owed by deducting amounts from future Medicaid program payments.

V. Total Monetary Recoveries

The Social Security Act requires that money recovered by a state through a state false claims act be refunded to the federal government at the Federal Medical Assistance Percentage (FMAP) rate.[6] The State of Missouri's FMAP rate was 64.51% for fiscal year 2010 (10/1/09 to 9/30/10)[7] and 63.29% for fiscal year 2011 (10/1/10 to 9/30/11).[8] As such, approximately 63-64% of the state's Medicaid recoveries are returned to the federal government. In cases pursued jointly with the federal government, the federal share of MFCU recoveries is deducted prior to MFCU's receipt of funds. In state cases, the entire recovery is collected, forwarded to DSS, and the precise federal share is subsequently determined and appropriated back to the federal government. *See* §191.905.11, RSMo.

The MFCU had total recoveries of $45,675,485.37 as a result of investigations completed in Calendar Year 2010 and collected $27,682.48 in cases resolved prior to 2010, for a total amount recovered of $45,703,167.85 in 2010.

The total of state ordered recoveries for 2010 was $19,979,508.65 and the total of the federal ordered recoveries was $25,686,927.38[9]. Actual sums collected by MFCU in Calendar Year 2010 totaled $19,952,791.84. Recoveries on more significant cases rarely are paid at the time they are ordered, creating a disparity between the total ordered and the total collected on any given date.

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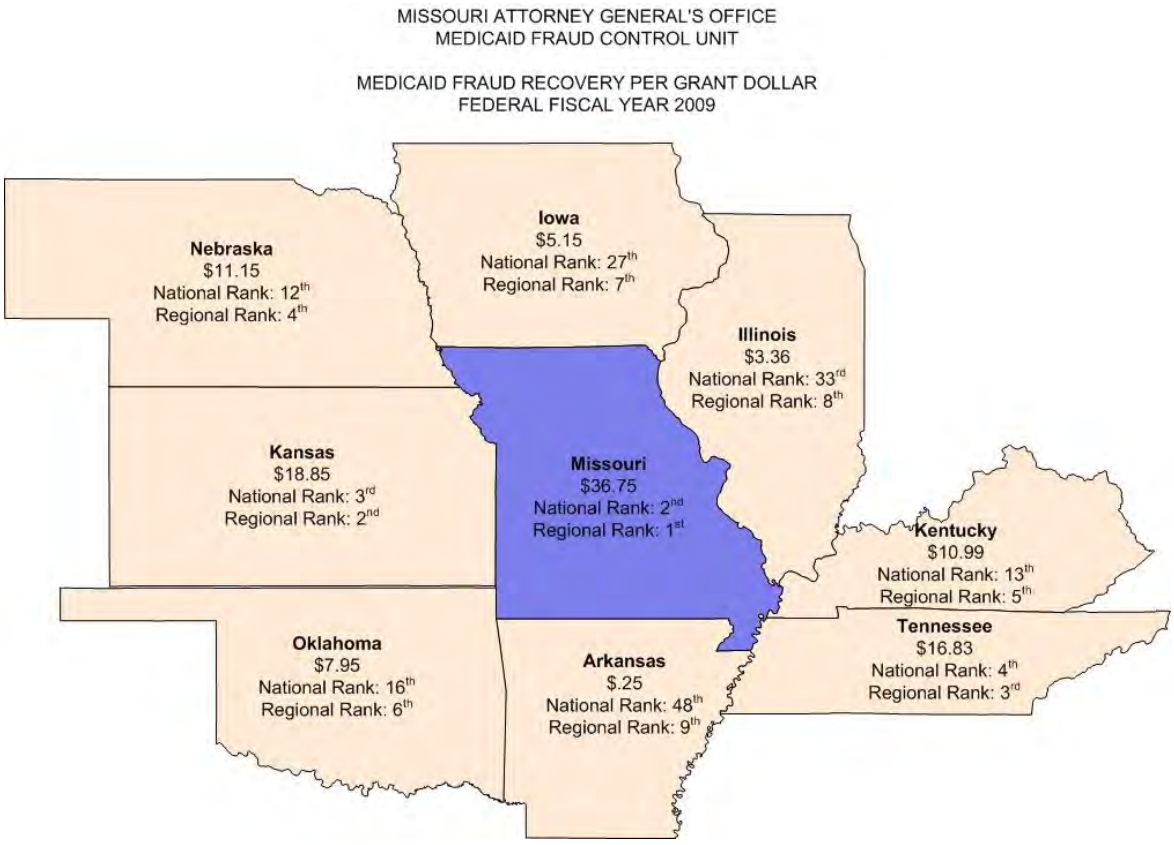
[6] *See* CMS Letter to State Officials, Oct. 28, 2008, SHO #08-004 (SHO Letter).
[7] Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, 73 Fed. Reg. 72,051 (Nov. 26, 2008).
[8] Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, 74 Fed. Reg. 62,316 (Nov. 27, 2009).
[9] Total recoveries slightly exceed the sum of state and federal ordered recoveries due to interest accrual.

The MFCU regularly participates in multi-state cases involving Medicaid fraud that may take a number of years to finalize. The resolution dates of these cases (whether resolved in one Calendar Year and potentially paid in another Calendar Year) can have a significant impact on the year to year recoveries.

Based on the most recent available national data[10] from the Department of Health and Human Services, Office of Inspector General (HHS-OIG), the MFCU obtained $36.75 for every grant dollar received – this ranked Missouri first in the region and second nationally. The below map illustrates Missouri's recovery per grant dollar as compared to our surrounding states:



VI. Arrests, Indictments and Convictions

The MFCU investigators cooperate fully in a number of joint criminal investigations with our federal counterparts. State prosecutions are referred by MFCU to local prosecutors and jointly pursued as per the terms of section 191.190.1, RSMo.

MFCU possesses no authority to arrest, so the following information was obtained by local law enforcement or the relevant federal authorities.

While most investigations are ultimately handled civilly, there were 7 formal state and federal criminal case resolutions in Calendar Year 2010. Felony prosecution can be commenced by either complaint or indictment. Not all Missouri counties utilize a grand jury and therefore many MFCU prosecutions proceed without an indictment. In these, several defendants were allowed to surrender without formal arrest, so there were 4 actual arrests made and 3 indictments issued.

[10] HHS-OIG collects and compiles its data on a federal fiscal year basis.